

Cross-Site BCC Research Ideas Proposed for Supplemental Funding

Please fill out the following template. As the goal is to identify research projects and collaborating partners, brevity is preferred. Please keep responses to one page or less for the first three items, and for remainder of the items one additional page for each primary research question. Each linked subquestion may have its own response page.

Statement of primary research question (3-5 sentences): Effective, low cost programs for changing health behaviors among under-served groups are a high priority target of public health research (Jeffrey, Danaher, Killen, Farquhar & Kinnier, 1982; Marcus, Owen, Forsyth, Cavell, & Fridinger, 1998). In particular, lower SES individuals are less likely to visit a physician for non-urgent health care and receive less advice from their physician on preventive health practices such as diet and physical activity (Billings, Zeitel, Lukomnik, Carey, Blank & Newman, 1993). Efforts to retain these underserved patients in behavioral trials have been weak at best. We know little from empirical research about how to retain participants in clinical trials from underserved populations. The purpose of this project is to better understand the effects on retention efforts of three different treatment delivery systems (telephone, in-person individual, and in-person group) for implementing change in physical activity and nutrition. To date, no studies of which we are aware have evaluated treatment compliance and follow up rate issues across delivery method.

Contribution of proposed activity to theory development/measurement enhancement (3-5 sentences): The goals of this project are two-fold: First, we aim to compare which treatment delivery system (telephone versus in-person individual versus in-person group) is best for retention of a minority, at risk population and for what compliance outcomes (nutrition versus physical activity). This is a process goal we believe has previously been neglected in empirical evaluation. The second goal is to compare which treatment delivery system is more effective at reaching its outcome goals (weight, nutrition, and physical activity changes) and which is more cost efficient at reaching these goals. This project is designed as a first step in understanding the relationship between mode of treatment delivery and retention of under-served participants. We hope to use this information to solicit further funding to compare treatment delivery systems of a broader scale with inclusion on a wider level and inclusive of more innovative technologies (i.e. telephone versus Internet versus in-person). Additionally, we hope in future studies to incorporate treatment matching (participant preference for delivery system) in an effort to further improve retention and adherence to compliance and outcome goals.

BCC's unique position to address this research question (2-3 sentences): The BCC is in a unique position to address this question since data exist on target populations (e.g. at risk, low SES, women) with physical activity and/or nutrition interventions and outcomes. Follow up rates and treatment compliance information is available both within and across sites on these retention issues. Additionally, the BCC represents many different constituencies and underserved populations that this project is particularly interested in understanding.

For one primary research question or several related subquestions (several related research issues may be packaged together if doing so presents a logical clustering) please address the following issues.

Specific research question and hypotheses (3-5 sentences): The research question is which treatment delivery system for an intervention on changes in weight, physical activity, and nutrition is best for the following: (a) treatment compliance to physical activity or nutrition interventions; (b) retention of underserved minorities; and (c) meeting its outcome goals. We hypothesize that while all treatment delivery systems will achieve their outcome goals post-treatment, those including more individualized approaches (in-person) will have better results across time. However, we also hypothesize that the approaches designed to serve the most people will be the most efficient at reaching its goals (telephone).

Sites (List BCC sites that will be involved --there must be a minimum of three. Also indicate if these sites represent any special populations). All sites at the December 2001 R&R meeting expressed an interest. Particular population interest groups were IIT (at risk for CHD), UT (under-served low SES adults), and ORI (at risk women with diabetes). Additional sites may be interested who were not represented at the last meeting. We will firm up participation on the next conference call in January.

Data (What general types of data will be collected and/or analyzed. Indicate if existing or new data is being proposed): We will collate retention data (numbers of drop-outs, lost to follow up, deaths, missed visits versus completers); intervention compliance data (% logs and % attendance), and outcome data (nutrition, physical activity, and weight change) from participating sites who collected this data as part of their original project. .

Time frame (specify can be done immediately with existing baseline data and what might need to wait for outcome data, and how long proposed activities will take): This is proposed as a one-year project. The project will primarily entail the collection of the data from the sites that wish to participate, the synthesis and organization of the data, and the analysis of the data. Because new data is not being collected, we do not anticipate time constraints or complications requiring more time. Throughout the project the retention questions are considered primary, while the outcome questions are an additional interest. This project requires the last follow up visits to have occurred in the participating sites and then approximately one year to collate and analyze these data.

Analysis plans (all that is needed is a brief statement about overall analytical approach, identification of data analyst(s), whether this is to be done centrally or not, and coordination with data analysis and methods group):

This is designed as 3 separate, 3 (delivery system) X 2 (nutrition versus physical activity) analyses of variance with retention and outcomes as the dependent variables. The results will be analyzed centrally and ideally with the data analysis and methods group.

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Estimated Resources (direct dollars only) and brief budget justification (e.g., what % effort for what types of activities). We anticipate that the major expense for this project will be on statistical consultation. We anticipate hiring a statistical consultant at 50% time for 1 year and also a graduate student to collate and prepare the data from participating sites (approximately \$75,000-\$100,000). Additionally, we will devote 10% of our time to this endeavor.

Team leader/Team members:

Tamara Sher, Lynne Braun, Jennifer Tennant, Mace Coday